STATE OF CALIFORNIA

HEALTH QUESTIONNAIRE

STD. 610 HQ (REV. 5-96) (Page 1 of 2)

Clear Print

STATE LAW AND THE AMERICANS WITH DISABILITIES ACT REQUIRE APPLICANTS TO FILL IN QUESTIONS ON BOTH SIDES OF THIS FORM ***ONLY AFTER A JOB OFFER HAS BEEN MADE***

DATE JOB OFFER MADE

SOCIAL SECURITY NUMBER *(Optional - See Privacy Statement below.)*

THIS AREA TO BE COMPLETED BY HIRING AGENCY - COMPLETED QUESTIONNAIRE WILL BE RETURNED TO HIRING AGENCY

APPLICANT NAME *(Last)* *(First)* *(Middle)*

AGENCY NAME

APPLICANT ADDRESS *(Number and Street)* *(City)* *(State)* *(ZIP Code)*

AGENCY ADDRESS

CLASS TITLE

HIRING MANAGER'S NAME AND TELEPHONE NUMBER

APPOINTMENT TYPE

☐ PERMANENT ☐ TAU ☐ LIMITED TERM

(If reinstatement, enter dates of previous State employment)

☐ REINSTATEMENT

DESIRED APPOINTMENT DATE

CERTIFICATION NUMBER

CURRENT OCCUPATION

THIS AREA TO BE COMPLETED BY THE APPLICANT

DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.

Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. **"YES"** answers to questions 1 - 43 below must be explained in the space provided on the back of this form.

BIRTH DATE ☐ MALE ☐ FEMALE HEIGHT WEIGHT

For questions 1-31, have you ever had or do you have the following:

ITEM	*YES*	*NO*
1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma		
2. Residuals of poliomyelitis		
3. Hepatitis, jaundice, or other liver ailments		
4. Cancer, malignant tumor, or cysts		
5. Diabetes or sugar in urine		
6. Pernicious anemia, leukemia, or other blood disorder or ailment		
7. Mental illness or nervous breakdown		
8. Any disorder of the nervous system		
9. Seizure disorder or loss of consciousness		
10. Severe headaches or migraine		
11. Heart trouble--including circulatory disease		
12. Rheumatic fever		
13. Any defect of bones or joints, including amputations, dislocations, or broken bones		
14. Rheumatism, arthritis, or bursitis		
15. Back pain or back injury		
16. Head injury		
17. Any problems with hips, knees, ankles, or feet		
18. Any problems with hands, elbows, or shoulders		
19. Fainting spells or dizziness		
20. Skin trouble		
21. Allergies		
22. Sensitivity to dust or smoke		
23. High or low blood pressure		
24. Varicose veins		
25. Stomach or duodenal ulcer or other bowel problem		
26. Rupture or hernia		

ITEM	*YES*	*NO*
27. Gall bladder trouble		
28. Kidney or bladder trouble		
29. Shortness of breath		
30. Any speech impairment		
31. History of addiction to drugs or alcohol		
32. Do you wear or have you ever worn glasses?		
33. Do you or have you ever worn contact lenses?		
34. Have you had any eye injury, surgery, or disease?		
35. Are you blind in one eye?		
36. Are you blind in both eyes?		
37. Do you wear a hearing aid or have you had at any time a problem with your hearing?		
38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2.		
39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address.		
40. Are you taking any medication now or in the last 12 months? If yes, what?		
41. Have you ever been hospitalized? If yes, list reason and date of hospitalization?		
42. a. Have you had an illness or injury which caused you to lose time from work?		
b. Does this illness or injury continue to limit your ability to perform certain types of work?		
43. Have you ever had any other illness, injury or physical condition not named above (exclude minor problems such as colds, flu, etc.)?		

(Continue on reverse.)

PRIVACY NOTICE

Official Responsible: Medical Officer, State Personnel Board, P.O. Box 944201, Sacramento, CA 94244-2010; **Authority**: Government Code Section 18931; **Purpose**: The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; **Providing Information:** Medical clearance is required prior to employment in State service; **Effects of Not Providing Information:** Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous; **Access:** Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

HEALTH QUESTIONNAIRE

Please write your own account and your own evaluation of all items to which you have answered "YES" to the prior questions. Include DIAGNOSIS, DATE OF ONSET, YOUR PRESENT CONDITION AS YOU EVALUATE IT and what accommodations to your limitations, if any, you feel you may require to perform satisfactorily the duties of the position for which you are applying without endangering the health and safety of yourself or others. **Return this completed form to the hiring agency unless (1) advised otherwise by the hiring agency, or (2) for strong personal reasons you prefer to send it directly to the Medical Officer, State Personnel Board, P.O. Box 944201, Sacramento, CA 94244-2010. If you choose the latter, be sure to notify the hiring agency you have done so.**

NAMES OF DOCTORS WHO WERE CONSULTED FOR TREATMENT OF CONDITION DESCRIBED ABOVE	***DOCTORS' ADDRESSES***

CERTIFICATION: *I certify that I have provided true and complete information concerning my health. (Any misrepresentation or material omission may be cause for dismissal.)*	APPLICANT'S SIGNATURE	DATE SIGNED	TELEPHONE NUMBER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: Any licensed physician, other licensed practitioner, hospital, clinic, or other medically-related facility, United States Veterans Administration, military or selective services which are in the possession of medical records pertaining to the person named on the reverse of this form.

In order to assist in determining my eligibility for employment with the State of California, I authorize you to copy and to transmit to the medical office listed below, any and all data and records concerning my physical and mental health with the following exceptions:

This authorization shall be valid for a period of 90 days after the date of my signature or earlier if revoked by me in writing to the State Personnel Board.

FROM: MEDICAL OFFICER
STATE PERSONNEL BOARD
P.O. BOX 944201
SACRAMENTO, CA 94244-2010

I have a right to receive a copy of this authorization upon request.

APPLICANT'S SIGNATURE	DATE SIGNED

APPLICANT--DO NOT WRITE BELOW THIS LINE--DELEGATED AUTHORITY OR STATE PERSONNEL BOARD MEDICAL OFFICER ONLY

REVIEWER

☐ **APPROVED** ☐ **QUESTIONABLE**--*Subject to Proper Placement (STPP)* ☐ **DISAPPROVED**

IF DISAPPROVED, STATE JOB-RELATED RATIONALE; IF STPP, STATE RESTRICTIONS

REVIEWING AUTHORITY'S SIGNATURE	DATE SIGNED	TELEPHONE NUMBER

REVIEWING AUTHORITY'S NAME *(Typed or printed)*